

PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, August 24, 2004, at 10:00 a.m., at the Massachusetts Department of Public Health, Henry I. Bowditch Public Health Council Room, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Commissioner/Chair Ms. Christine Ferguson, Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Maureen Pompeo, Mr. Albert Sherman, Dr. Thomas Sterne, Mr. Gaylord Thayer, Jr., and Dr. Martin Williams. Ms. Janet Slemenda was absent. Also in attendance was Attorney Donna Levin, General Counsel.

Chair Ferguson announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, chapter 30A, section 11A ½. Chair Ferguson announced a presentation entitled "Traumatic Brain Injuries in Massachusetts: 1995-2000", by Holly Hackman, MD, MPH, Director, Injury Surveillance Program, Center for Health Statistics, Information, Research and Evaluation, Massachusetts Department of Public Health.

The following members appeared before staff to discuss and advise on matters pertaining to their particular interests: Dr. Holly Hackman, Director, Injury Surveillance Program, Center for Health Statistics, Information, Research and Evaluation; Ms. Sally Fogerty, Assistant Commissioner, Center for Community Health; Ms. Joyce James, Director, Determination of Need Program; and Deputy General Counsel, Carol Balulescu.

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETINGS OF JUNE 22, 2004 AND JULY 27, 2004:

Records of the Public Health Council Meetings of June 22, 2004 and July 27, 2004 were presented to the Council for approval. After consideration, upon motion made and duly seconded, it was voted: (unanimously) to approve the Records of the Public Health Council Meetings of June 22, 2004 and July 27, 2004 as presented.

PERSONNEL ACTIONS:

In letters dated August 5, 2004, Val W. Slayton, MD, MPP, Interim Director of Medical Services, Tewksbury Hospital, Tewksbury, recommended approval of appointments and a reappointment to the various medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted unanimously, That, in accordance with the recommendation of the Interim Director of Medical Services of Tewksbury Hospital, under the authority of the Massachusetts General Laws, chapter 17, section

6, the following appointments and reappointment to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning August 1, 2004 to August 1, 2006:

APPOINTMENTS: **MASS. LICENSE NO.:** **STATUS/SPECIALITY:**

David P. Morin, MD	54798	Active Internal Medicine
Herminia D. Rosas, MD	151574	Neurology

REAPPOINTMENT: **MASS. LICENSE NO.:** **CATEGORY/SPECIALTY:**

Anthony Boschetti, DMD	14919	Dentist/General Dentistry
------------------------	-------	---------------------------

In a letter dated August 9, 2004, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of appointments and reappointments to the medical and allied health professional staff of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted, unanimously, That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointments to the medical and allied health professional staff of Lemuel Shattuck hospital be approved:

APPOINTMENTS: **MASS. LICENSE NO.:** **STATUS/SPECIALTY:**

Joyce Baker, MD	59892	Consultant/Psychiatry
Georgina Garcia, MD	220339	Consultant/Psychiatry
Alexander Pan, MD	220131	Consultant/Internal Medicine
James Weitzman, MD	220153	Consultant/Internal Medicine

Emily Robinson, NP	216235	Allied Health Professional
--------------------	--------	----------------------------

REAPPOINTMENTS: **MASS. LICENSE NO.:** **STATUS/SPECIALTY:**

Rachelle Hotz, MD	53458	Active/Psychiatry
Barry Collet, DPM	1489	Consultant/Podiatry
Jeffrey Cooper, MD	79976	Consultant/Surgery
John Hsu, DMD	15958	Dentistry
John Jameson, MD	72421	ENT Surgery

Sally Guy, CNS	161055	Allied Health Professional
----------------	--------	----------------------------

In a letter dated August 2, 2004, Blake Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of a reappointment to the consulting staff of Western Massachusetts Hospital. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following reappointment to the medical staff of Western Massachusetts Hospital be approved:

<u>REAPPOINTMENT:</u>	<u>RESPONSIBILITY:</u>	<u>LICENSE NO.:</u>
Marc Fisher, DPM	Podiatry	1588

STAFF PRESENTATION: NO VOTE, INFORMATIONAL ONLY

“TRAUMATIC BRAIN INJURIES IN MASSACHUSETTS: 1995-2000”, BY HOLLY HACKMAN, MD, MPH, DIRECTOR, INJURY SURVEILLANCE PROGRAM, CENTER FOR HEALTH STATISTICS, INFORMATION, RESEARCH AND EVALUATION, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH”

Holly Hackman, MD, MPH, Director, Injury Surveillance Program, Center for Health Statistics, Information, Research and Evaluation, said in part, “Traumatic brain injuries are an important health problem in Massachusetts and across the nation. Each year, an estimated 1.5 million individuals in the U.S. sustain a traumatic brain injury. This represents eight times the number of people diagnosed with breast cancer and thirty-four times the number of new cases of HIV/AIDS. Compared with other types of injury, brain injuries are among the most likely to cause death or permanent disability. Nationwide, approximately 50,000 of those sustaining a traumatic brain injury will die of their injury, and another 80,000-90,000 experience the onset of long-term or lifelong disability. The majority of individuals who sustain moderate/severe traumatic brain injury experience significant physical, behavioral/psychiatric, psychosocial cognitive, and medical problems. These health problems negatively impact functional independence, community access and living skills, vocational outcomes, and psychosocial development, and may extend throughout a lifetime. Research has shown that traumatic brain injury can contribute to increase in high school dropout rates, unemployment, risk for substance abuse, psychiatric hospitalizations including suicide attempts, and criminal activity. Injured individuals can benefit from and often require specialized services and supports to improve their health overall and increase their levels of independence and functioning.”

Dr. Hackman continued, “An estimated one in every 170 Massachusetts residents experiences a traumatic brain injury severe enough to result in death, hospital admission or emergency department treatment each year. In 2000, there were 551 traumatic brain injury fatalities and another 3,965 traumatic brain injury-related hospitalizations among Massachusetts residents.

Further, based on 2002 data, there are another 32,640 emergency department visits annually in Massachusetts for this injury. For every person who dies from a traumatic brain injury, an estimated seventy are treated and released from emergency departments. Falls became the leading cause of traumatic brain injury-related fatalities in 1999, surpassing firearm-related traumatic brain injury fatalities. Falls were also the leading cause of non-fatal traumatic brain-injury related hospital discharges from 1995 through 2000. The total charges for traumatic brain injury related hospitalizations in 2000 for Massachusetts state residents was over \$102 million. More than half of these charges were paid through public sources. Most traumatic brain injuries are preventable. Injury prevention efforts, including those directed toward prevention of traumatic brain injuries, are often grouped into three major areas: education, enactment and enforcement of laws, and environmental modification or engineering. Because the sequence of events leading up to these injuries frequently follows a predictable pattern, knowing the causes and circumstances behind these injuries can assist groups around the state in developing effective prevention strategies. Many proven strategies to prevent traumatic brain injuries exist, the challenge is to implement them.”

Dr. Hackman concluded, “Although the rates of fatal traumatic brain injuries among Massachusetts residents compare favorably with the U.S. as a whole, this report underscores the need for continued efforts to reduce the number of these events. As shown by the data, some of the major causes of traumatic brain injuries in Massachusetts are falls, especially among the elderly, motor vehicle occupant injuries, violence against infants, and firearm-related suicides. Prevention of each of these often require a multi-faceted approach involving education, enactment and enforcement of laws, and modifications in the environment where injuries occur. Ongoing surveillance of traumatic brain injuries, including the systematic collection of data on incidence, circumstances, and outcomes is a critical first step in developing a public health approach to preventing these events...”

Magnitude and Trends:

- From 1995 through 2000 there were 3,262 traumatic brain injury deaths among Massachusetts residents, an average of 544 deaths per year (8.6/100,000). In 2000, 22% of all injury fatalities in Massachusetts were associated with a traumatic brain injury.
- From 1995 through 2000, the traumatic brain injury fatality rates remained relatively stable.

Leading Causes:

- The three leading causes of traumatic brain injury deaths from 1995 through 2000 were:

Firearms: an average of 141 deaths/year. More than a quarter (26%) of all traumatic brain injury fatalities during this period were firearm-related. Eighty percent of firearm-related traumatic brain injury deaths were suicides, and 19 % were homicides. From 1998 to 2000, firearm-related TBI deaths decreased 23%.

Falls: an average of 121 deaths/year. Twenty-two percent of all traumatic brain injury fatalities during this period were fall-related. Fall-related traumatic brain injury deaths increased 42% from 1995 to 2000. Fall-related traumatic brain injury deaths outnumbered firearm-related traumatic brain injury fatalities beginning in 1999. Men and women age 75 and over had the highest rates of fatal traumatic brain injuries due to a fall (an average of 65 deaths each year). Twenty-two percent of persons age 75 and over, who suffered a fatal traumatic brain injury due to a fall in 2000, fell from stairs or steps.

Motor Vehicle Occupants: An average of 88 deaths/year. Sixteen percent of all traumatic brain injury fatalities during this period involved occupants of motor vehicles. Young persons 15-19 years of age experienced the highest rate of traumatic brain injury-related motor vehicle occupant fatalities, accounting for, on average, 20% of these deaths each year. Twenty-one percent of all motor vehicle-related traumatic brain injury fatalities in 2000 were among pedestrians or bicyclists.

- Sixty percent of traumatic brain injury deaths were unintentional, 22% were due to suicide, and 9% were due to homicide.
- Pedestrian activities were the leading cause of traumatic brain injury-associated deaths among children ages 1 through 9 years, while motor vehicle occupant was the leading cause of traumatic brain injury deaths for youths 10 to 19 years of age from 1995 through 2000.

Risk Groups:

- Traumatic brain injury fatality rates for males were 2.4 times higher than those for females from 1995 through 2000.
- Persons age 85 and older experienced the highest rates of traumatic brain injury related death, compared with other age groups.
- Among racial/ethnic groups, Black non-Hispanics experienced the highest rates of fatal traumatic brain injuries, 1.3 times higher than the second leading risk group (White non-Hispanics).

- Sixty-one percent of firearm-related traumatic brain injury deaths among Black non-Hispanics in 2000 were due to homicide.
- Eighty-two percent of traumatic brain injury deaths among White non-Hispanics were due to suicide.
- Infants under age one experienced the highest rates of homicide-related traumatic brain injuries compared to all other age groups from 1995 through 2000. Young people 20-24 years of age, however, had the highest overall rates of homicide during this time period. The higher rates of traumatic brain injuries among infant homicides is likely explained by the difference in the mechanisms or causes of these homicides. Among persons 20-24 years of age, the leading mechanism of homicide was a firearm. The leading causes of homicides among infants less than 1 year of age were “unspecified” and “other maltreatment syndromes”.

REGULATIONS:

FINAL PROMULGATION OF PROPOSED AMENDMENT TO DETERMINATION OF NEED REGULATIONS 105 CMR 100.000 GOVERNING FILING DAYS FOR APPLICATIONS FOR INNOVATIVE SERVICES AND NEW TECHNOLOGY:

Ms. Joyce James, Director, Determination of Need Program, said, “The purpose of this memorandum is to request the Public Health Council’s approval to finalize an emergency amendment to the Determination of Need Regulations 105 CMR 100.302, governing Filing Days for Applications and Amendments. On June 22, 2004, the Council adopted the emergency amendment to delay the filing day of applications for Neonatal Intensive Care Units until the first business day of August 2005. The June 22, 2004 emergency amendment was necessary because the Department and its Perinatal Advisory Group were in the process of reviewing the maternal and newborn care sections of 105 CMR 130.000. The final revised regulations, which may affect the DON process in addressing the need for NICU beds, would not have been completed by the time of the August 2004 filing day of NICU applications. Thus, the Department acted prior to the scheduled filing date and postponed the filing date for one year. The Department held a public hearing on August 3, 2004 in the Public Health Council Conference Room, 250 Washington Street, Boston, MA. Two people attended the hearing but did not testify. Dr. Steven A. Ringer, Director of Newborn Medicine at Brigham and Women’s Hospital, submitted written comments supporting the amendment. Dr. Ringer states that the delay should allow the Department and its Perinatal Advisory Committee and hospitals and other representatives advising the Department to complete the process of updating the maternal-newborn sections of the hospital licensure regulations. The Department asks that this amendment be approved for final promulgation as presented today. Following your approval,

the Department will file a Notice of Compliance with the Secretary of the Commonwealth to make the emergency amendment permanent.”

After consideration, upon motion made and duly seconded, it was voted (unanimously), to **approve Final Promulgation of Proposed Amendment to Determination of Need Regulations 105 CMR 100.000 Governing Filing Days for Applications for Innovative Services and New Technology**; That a copy of the amended regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,793**. A public hearing was held on August 3, 2004.

REQUEST TO PROMULGATE AMENDMENT TO 105 CMR 130.000, HOSPITAL LICENSURE, REGARDING INCORPORATION OF SUBSTANCE ABUSE REGULATIONS:

Deputy General Counsel Carol Balulescu said “The purpose of this memorandum is to request the Council’s approval to promulgate a new section, 105 CMR 130.365, to 105 CMR 130.000, the hospital licensure regulation. The purpose of the proposed amendment is to incorporate by reference the Department’s substance abuse facilities regulations. Pursuant to M.G.L. cc. 111B and 111 E the Department is charged with oversight of facilities that provide treatment for substance abuse and has promulgated regulations for the licensing and approval of such facilities. The Bureau of Substance Abuse Services statutes and regulations do not, however, apply to general hospitals licensed by the Department pursuant to section 51 of M.G.L.c.111. Because licensed general hospitals often provide the same or similar services as those provided by BSAS-licensed drug and alcohol treatment facilities, the BSAS-licensed substance abuse facilities regulations apply equally to those substance abuse programs provided by general hospitals. The Department held a public hearing on the proposed amendment on August 3, 2004. No one offered oral testimony at the hearing, nor did the Department receive any written comments on the proposed amendment. The Department asks that you approve the amendment for promulgation. Following your approval, the Department will file the amendment with the Secretary of the Commonwealth. The amendment will become effective upon publication in the Massachusetts Register on September 10, 2004.”

After consideration, upon motion made and duly seconded, it was voted (unanimously) to **approve the Request to Promulgate Amendment to 105 CMR 130.000, Hospital Licensure, Regarding Incorporation of Substance Abuse Regulations**; that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,794**. A public hearing was held on August 3, 2004.

The meeting adjourned at 11:00 a.m.

Christine C. Ferguson, Chair
Public Health Council

LMH/SB